National Certification Commission for Acupuncture and Oriental Medicine

PRE-GRADUATION VERIFICATION FORM

Oriental Medicine/Acupuncture/Chinese Herbology

School/Institute: _____

_____

Contact Person: _____

Phone Number: _____ Email: _____

Time Zone: (circle one) Eastern Central Mountain Pacific Hawaii

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Name of Student: _____
Last First Middle

Social Security Number: _____

Enrollment Date (mm/dd/yy): _____

ACADEMIC HOURS

Please report the total number of *hours completed* as of the date this form is submitted.

(a) Total Completed Hours	(b) Total Didactic Hours	(c) Total Clinical Hours	(d) The clinical hours in column (c) include Chinese Herbology
			Yes ☐ No ☐

Student is authorized to take the following examination(s):

☐ **Foundations of Oriental Medicine** ☐ **Acupuncture w/ Point Location**

☐ **Biomedicine** ☐ **Chinese Herbology**

_____ _____
Authorized Signature Title

OFFICIAL SEAL
(Required)

_____
Date

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